John Elias Baldacci
Governor

John R. Nicholas
Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

Bureau of Medical Services

October 8, 2004

TO: Interested Parties

FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services

SUBJECT: Adopted Rule: MaineCare Benefits Manual, Chapters II & III, Section 102, Rehabilitative Services.

This letter gives notice of changes for MaineCare rules to permanently adopt a rule regarding Rehabilitative Services.

This rule adopts: several new definitions; revised medical eligibility requirements; and three levels of care. Weekly service limits for each level of care and utilization review (UR) requirements are adopted. Chapter III adopts new procedure codes and reimbursement rates. This rule updates procedures for provisional accreditation in Appendix #1 and transfers responsibility for this process to DHHS. Appendix # 2 "Levels of Functioning" has been deleted.

This rule involves comprehensive changes in the operation of rehabilitative services. Providers should apply the new eligibility requirements to all new admissions and assign the members to the appropriate level of care. Procedures for starting services for new admissions are described in Section 102.08-3, Start-of-care. The Brain Injury Assessment Tool (BIAT) and definitions will be posted to the Department's website available for downloading. Some changes will be phased-in. Informational instructions will be issued soon to providers.

The Department held a public hearing on August 24, 2004, 442 Civic Center Drive, Augusta, Maine. Comments were accepted until September 3, 2004. All comments were considered and, as appropriate, recommended changes were incorporated into the final rule.

Rules and related documents may be reviewed and printed from the Bureau of Medical Services website at http://www.state.me.us/bms/rulemaking/ or, for a fee, interested parties may request a paper copy of rules by contacting Policy and Provider Services at 207-287-9368. The TDD/TTY number is: (207) 287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, Bureau of Medical Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual,
Chapters II & III, Section 102, Rehabilitative Services.

ADOPTED RULE NUMBER:

CONCISE SUMMARY: This rule adopts: several new definitions; revised medical eligibility requirements; and three levels of care. Weekly service limits for each level of care and utilization review (UR) requirements are adopted. Chapter III adopts new procedure codes and reimbursement rates. This rule updates procedures for provisional accreditation in Appendix #1 and transfers responsibility for this process to DHHS. Appendix # 2 "Levels of Functioning" has been deleted.

See www.maine.gov/bms/MaineCareBenefitsManualRules.htm for rules and related rulemaking documents.

EFFECTIVE DATE: November 1, 2004

AGENCY CONTACT PERSON: Julie Tosswill

AGENCY NAME: Division of Policy & Provider Services

ADDRESS: 11 State House Station
442 Civic Center Drive
Augusta, Maine 04333-0011

TELEPHONE: (207) 287-9360
FAX (207) 287-9369
TTY: 1-800-423-4331 or 207-287-1828 (Deaf/
Hard of Hearing)

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SECTION 102 **REHABILITATIVE SERVICES** 8/1/90

102.01 PURPOSE

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The purpose of this rule is to cover rehabilitative services for eligible members who have sustained a brain injury. This section does not include coverage for services for people with brain injuries that are congenital or induced by birth. Rehabilitative services are specialized, interdisciplinary, coordinated and outcomes focused. The services are designed to address the unique medical, physical, cognitive, psychosocial and behavioral needs of members with acquired brain injuries. Limitations apply; services are appropriate if there is the potential for rehabilitation and the expectation of functionally significant improvements in the member's status, or in certain cases where services are necessary because their withdrawal would result in the member's measurable decline in functional status.

102.02 DEFINITIONS

102.02-1 Authorized Agent is an organization authorized by the Department to perform functions under a valid contract or other approved, signed agreement.

102.02-2 Brain Injury is an insult to the brain resulting directly or indirectly from trauma, infection, anoxia, or vascular lesions, and not of a degenerative or congenital nature, but which may produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning. It can also result in the disturbance of behavioral or emotional functioning. These impairments may be either temporary or permanent and cause partial or total functional disability or psychosocial maladjustment. This does not include brain injuries that are induced by birth.

102.02-3 CARF is the Rehabilitation Accreditation Commission.

102.02-4 Collateral Contact is a direct (face-to-face) contact on behalf of the member by a provider to obtain information from, or discuss the member's case with, other professionals, caregivers, or others included in the treatment plan in order to achieve continuity of care, coordination of services and the appropriate services for the member. Discussions or meetings among staff employed by a single provider on behalf of the member are not to be considered collateral contacts, and are not a billable service.

102.02-5 Functionally Significant Improvement is the demonstrable measurable increase in the member's ability to perform specific tasks or motions that contribute to independence outside the therapeutic environment.

102.02-6 Individualized Treatment or Service Plan is a plan of rehabilitative care based on an individual assessment made by a professional or other qualified staff of a member's medical and social needs (Professional and other qualified staff are defined in Section 102.08-5.), or otherwise authorized by the Department, or the Department's Authorized Agent (defined in Section 102.02-1), at the discretion of the Department.

102.02 **DEFINITIONS** (Cont.)

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102.02-7 Intensive Rehabilitation Nursing Facility (NF) Services for Individuals with a Brain Injury means services that are delivered in a part of a NF and reimbursed a special rate pursuant to Chapter III, Section 67, Principles of Reimbursement for Nursing Facilities, Intensive Rehabilitation NF Services for Brain Injured Individuals.

102.02-8 Rehabilitation Potential is the documented expectation of measurable, functionally significant improvement in the member's condition in a reasonable, predictable period of time as the result of the prescribed treatment plan, as determined by a qualified professional. The documentation of rehabilitation potential must include the reasons used for this expectation.

102.02-9 Rehabilitative Provider is a distinct organizational entity in a distinct physical setting, which provides coordinated and integrated services that include evaluation and treatment related to the member's functional limitations and the member's response to treatment. Members may require some services away from the provider's physical setting in order to obtain optimal level of functioning. The services are designed to prevent and/or minimize chronic disabilities while restoring the individual to the optimal level of physical, cognitive, and behavioral function within the context of the person, family, and the community. The services may be highly specialized to address unique service needs of the individual, and it may be designed to prevent deterioration and maintain an optimal level of function over time.

102.02-10 Rehabilitative Services are those covered services provided under the direction of a neuropsychologist or physician and delivered by a neuropsychologist, physician, occupational therapist, physical therapist, registered nurse, speech pathologist or other qualified staff meeting the qualifications identified in Section 102.08-5 of this Manual.

102.02-11 Significant Change/Relapse is indicated when the member's score on the Department's authorized brain injury assessment tool increases from the most recent score to a score of at least "3" on one item, in two or more domains.

102.03 **ELIGIBILITY FOR CARE**

A member is eligible to receive services under this Section if he or she meets both the General Eligibility Requirements for MaineCare and the Specific Eligibility Requirements detailed in this Section. It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services, as described in Chapter I.

102.03-1 **General Eligibility Requirements for MaineCare**

Individuals must meet the financial eligibility criteria as set forth in the MaineCare Eligibility Manual (MEM). Some members may have restrictions on the type and amount of services they are eligible to receive, based on the MEM.

102.03 **ELIGIBILITY FOR CARE** (Cont)

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11-1-04 102.03-2 **Specific Eligibility Requirements**

A member must meet the following criteria:

A. Has a diagnosis of brain injury, as defined in Section 102.02-2 and confirmed by a clinical evaluation as defined in Section 102.05-10; and

B. Is not receiving acute hospital rehabilitation services; and

C. Is not receiving intensive rehabilitation NF services as defined in Section 102.02-7; and

D. Meets the requirements of one of the following three levels of care:

1. **Level I** A member meets the medical eligibility requirements for Level I if he or she:

   a. Scores at least "3" on one item, in two or more domains in the Department's authorized Brain Injury Assessment Tool; (see Section 102.03-3) and

   b. i) Is less than 24 months from the date of injury of significant BI;

   or

   ii) Experiences a significant change/relapse (defined in Section 102.02-11) from a previously higher level of physical, cognitive or behavioral functioning; and

   c. Is not currently a resident of a nursing facility; and

   d. Has documented rehabilitation potential (defined in Section 102.02-8).

   OR

2. **Level II** A member meets the medical eligibility requirements for Level II if he or she:

   a. Scores at least "2" on one item, in two or more domains in the Department's authorized Brain Injury Assessment Tool; (see Section 102.03-3) and

102.03 **ELIGIBILITY FOR CARE** (Cont.)

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b. i) Has experienced documented change in status requiring licensed/certified staff to regain baseline;

or

ii) Requires licensed/certified services to continue improvement established in Level I; and

c. If the member is currently receiving services in a nursing facility setting that are not intensive rehabilitative NF services, then the member must meet all of the following criteria:

i) It has been less than 6 months from the date-of-injury of significant brain injury; and

ii) The member's clinical evaluation documents rehabilitation potential (defined Section 102.02-8); and

iii) The member requires licensed/certified services to continue improvement; and

iv) The member has limited or no other access to rehabilitative services; and

v) The member expresses a desire to move to a less restrictive setting; and

vi) Discharge to a less restrictive living arrangement has been identified in the discharge potential section of the Minimum Data Set (MDS) (which is conducted by the NF) and active planning for discharge is documented in the member's NF plan of care.

OR

3. **Level III**. A member meets the medical eligibility requirements for Level III if he or she:

a. Scores at least "2" on one item, in two or more domains in the Department's authorized Brain Injury Assessment Tool, (see Section 102.03-3); and

b. Requires this level of service to achieve documented rehabilitation potential or maintain function; and

c. Is not currently a resident of a nursing facility.

102.03 **ELIGIBILITY FOR CARE** (Cont.)

102.03-3 **Brain Injury Assessment Tool Criteria**

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The member must have each item below rated by clinicians (any of the following, as appropriate: physician, neuropsychologist, registered nurse, occupational therapist, physical therapist, speech-language pathologist, social worker, professional counselor, or therapeutic recreation specialist) who have evaluated the member, are familiar with the member and the member's history, and have experience in the treatment of brain injury. Each item must be rated on the Department's Brain Injury Assessment Tool (BIAT) to indicate the level at which the person being evaluated experienced problems during the last two weeks. The Brain Injury Assessment Tool is available to view and copy on the Department's website. The Department or its Authorized Agent may conduct an assessment as a part of utilization review.

The following scale, or variations set forth within the BIAT, is used for rating.

0 None
1 Mild problem but does not interfere with activities, or interferes less than 5% of the time; may use assistive device or medication
2 Mild problem; interferes with activities 5-24% of the time
3 Moderate problem; interferes with activities 25-75% of the time
4 Severe problem: interferes with activities more than 75% of the time

The BIAT measures the following domains and constituent items:

A. Physical Function

Mobility
Use of hands
Dizziness
Vision
Audition

B. Language/Cognition

Attention/Concentration
Motor speech
Verbal communication
Nonverbal communication
Visuospatial abilities
Memory
Novel problem-solving
Executive function/prospective memory
Initiation
Impaired self-awareness

102.03 **ELIGIBILITY FOR CARE** (Cont.)

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C. Emotional Adjustment

Anxiety
Depression
Inappropriate social interaction
Irritability, anger, aggression
Sensitivity to mild symptoms
Psychotic symptoms
Problem behaviors
Danger to self or others

D. Independence

Eating/Self-care
Dressing/Self-care
Bathing/Self-care
Hygiene/Self-care
Toileting/Self-care
Information management and self-advocacy
Residence
Constructive roles
Managing money and finances

E. Medical

Pain and headache
Fatigue
Sleep disturbance
Medical self-care
Medication management and compliance

F. Substance Use

Alcohol use
Drug use
Nicotine use

G. Scoring

1. Does the member score at least "3" on one item in two or more domains? YES or NO

   If yes, member may be eligible for Level I, see Section 102.03-2.

102.03 **ELIGIBILITY FOR CARE** (Cont.)

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2. Does the member score at least "2" on one item in two or more domains? YES or NO

   If yes, member may be eligible for Level II or III services, see Section 102.03-2

[Note: BIAT items adapted from the Mayo-Portland Adaptability Inventory-4 (MAPI). Original MAPI available on line at http://www.tbims.org/combi/mapi/]

102.04 **DURATION OF CARE**

MaineCare will only cover medically necessary services for eligible members. Covered services are subject to utilization review (UR), as well as the limits in Section 102.06. Rehabilitative services are covered for an approved classification period for each eligible MaineCare member. Beginning and end dates of the member's classification period correspond to beginning and end dates for MaineCare reimbursement. MaineCare coverage will end on the classification period end date unless the Department or its Authorized Agent has authorized a new classification period. The Department reserves the right to request additional information to evaluate medical necessity.

102.05 **COVERED SERVICES**

A covered service is a service for which payment to a provider is permitted under this Section of the MaineCare Benefits Manual. The types of rehabilitative services that are covered for eligible individuals are the following:

102.05-1 Physician Services

Physician services may include, but are not limited to the following:

A. Assessment of the member's medical and rehabilitation needs; and provides the physician component of decisions regarding rehabilitation potential and the determination of predicted outcomes;

B. Regular and direct contact with the member to provide services that meet the identified medical and rehabilitative needs; active management and direction of the member's rehabilitation services to ensure these are consistent with the predicted outcomes; provision of medical care for continuing, unstable, or complex medical conditions, directly or through arrangements with other physicians; and

C. Collateral contact with other professionals, caregivers, and others included in the member's treatment plan, as defined in Section 102.02-4.

102.05 **COVERED SERVICES** (Cont.)

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102.05-2 Neuropsychologist Services

Neuropsychologist services may include, but are not limited to the following:

A. Assessment of intelligence, memory, and ability to learn, sensory-motor functions, speech and language abilities, spatial and construction abilities, academic skills, reasoning, personality, and vocational interest;

B. Treatment including individual and/or group cognitive remediation services, individual and/or group psychotherapy; and

C. Collateral contact with other professionals, caregivers, and others included in the member's treatment plan, as defined in Section 102.02-4.

102.05-3 Rehabilitation Nursing Services

The registered nurse in the rehabilitation setting focuses on promoting health and maximizing human potential. The nurse is an integral member of the health care team whose priorities are based on each patient's needs at any given time.

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The rehabilitation nurse assists the member in developing appropriate responses to situations, adjust the environment to meet the needs of the person with a disability, and promotes participation in society.

102.05-4 Therapeutic Recreation Specialist Services

Therapeutic recreation services are directed toward the correction of physical and mental impairments, and may include, but are not limited to, the amelioration of disorders such as attention-span deficits, cognitive difficulties, or dysfunctional behaviors.

102.05-5 Occupational Therapist Services

The occupational therapist maximizes the member's ability to perform functional daily living tasks such as feeding, bathing and dressing. The therapist's emphasis is on providing tasks meaningful to members with the goal of remediating perceptual and functional deficits, which affect performance.

102.05-6 Physical Therapist Services

The physical therapist uses a variety of modalities to maximize the member's physical capabilities. Treatment goals may include but are not limited to maintaining flexibility, facilitating movement, providing movement experiences and stimulation, especially tactile, vestibular, kinesthetic or proprioceptive.

102.05 **COVERED SERVICES** (Cont.)

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Treatment may be directed toward organizing functional learning in normal motor development sequence, teaching appropriate-level functional skills, as well as necessary collateral contacts.

102.05-7 Speech-Language Pathologist Services

The speech-language pathologist provides diagnosis and treatment for members with varying degrees of impairment in their communicative abilities.

Services for members may address speech, language, voice, and swallowing disorders. Group therapy may address communication skills, feeding problems and higher level cognitive/linguistic problems.

102.05-8 Social Worker Services

The social worker provides services that enable a member to integrate into the community by assisting the member to develop appropriate responses to his or her environment.

102.05-9 Professional Counselor Services

The professional counselor provides counseling services to assist the member in achieving more effective personal, emotional, social, educational and vocational development and adjustment.

102.05-10 Clinical Evaluation Services

A qualified neuropsychologist (defined in Section 102.08-5(B)) and/or a licensed physician who is Board certified, or otherwise Board eligible, in either physical medicine and rehabilitation or neurology, must conduct and supervise a clinical evaluation in collaboration with the interdisciplinary team, as part of the admission process. The findings of the evaluation form the basis for the specific rehabilitation goals and describe the types and frequencies of each service and the expected outcomes and timeframes. The evaluation must indicate the degree of functional impairment and assess the member's potential for physical and/or behavioral and/or cognitive rehabilitation, and meet the requirements of Section 102.08-7(A)(1). Reimbursement for brain injury evaluation services must not exceed 8 hours of service, per member, per occurrence of acquired brain injury.

MaineCare will reimburse for the clinical evaluation to confirm the diagnosis of brain injury, even if the member is not found eligible for services under this Section. These members should be provided with other service recommendations, as appropriate, to address needs identified by the clinical evaluation.

102.06 **LIMITATIONS**

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A. MaineCare will only cover services provided under one level of care (see Section 102.03-2) at a time for each eligible member under this Section.

B. A member may not receive coverage for services under this Section if he or she is involved in acute hospital rehabilitation services.

C A member may not receive coverage for services under this Section if he or she is receiving intensive rehabilitative NF services, as defined in Section 102.02-7.

D. The following limits apply to each member, per occurrence of brain injury, and are subject to applicable utilization review determinations:

1. MaineCare will only reimburse for Level I services for up to 15 hours per week, for no more than 180 consecutive calendar days, if the member has documented rehabilitation potential (see Section 102.02-8).

2. MaineCare will only reimburse for Level II services as follows:

a. Level II services must not exceed 15 hours per week for the first year for which the member is classified for this level, 10 hours per week for the second year, and 5 hours per week for a final third year. Members will not be covered for more than 3 years at this level of care.

b. If the member is classified as being eligible to receive Level II services under this Section while receiving services in a nursing facility that are not intensive rehabilitation NF services (as defined in Section 102.02-7) then the services may be provided for up to 15 hours per week, for no more than 6 months.

3. MaineCare will only reimburse for Level III services up to 22 hours per week.

E. Services must not duplicate services delivered under any other Section of the MBM, including but not limited to: Section 97, Private Non-Medical Institution Services; Section 12, Consumer Directed Attendant Services; Section 22, Home and Community-Based Waiver Services for the Physically Disabled; Section 19, Home & Community Benefits for the Elderly and for Adults with Disabilities; Section 96, Private Duty Nursing & Personal Care Services; Section 68, Occupational Therapy Services; Section 85, Physical Therapy Services; Section 110, Speech-Language Pathology Services; Section 105, Speech & Hearing Agencies; Section 111, Substance Abuse Treatment Services; Section 17, Community Support Services; and Section 65, Mental Health Services.

F. MaineCare will only reimburse for clinical evaluation services (described in Sections 102.05-10 and 102.08-7(A)) up to 8 hours of service, per member, per occurrence of acquired brain injury.

102.07 **NON-COVERED SERVICES**

Effective
11-1-04 Refer to Chapter I, General Administrative Policies and Procedures for rules governing non-covered services. Services that are primarily vocational, custodial, academic, socialization or recreational are not covered.

102.08 **POLICIES AND PROCEDURES**

102.08-1 Rehabilitative Services

In order for services to be reimbursable, a service must meet the following standards:

The provider must be accredited by the Rehabilitation Accreditation Commission (CARF) to provide brain injury rehabilitation services (other than vocational services, which are not covered by MaineCare,) or otherwise have an eighteen-month provisional certification from the Maine Department of Health and Human Services to cover the period the provider is working to secure CARF accreditation. The Department is responsible for determining compliance with the provisional certification standards in Appendix 1 of this Section. A copy of the Department-issued provisional certification, or evidence of current CARF accreditation, must be on file with the Bureau of Medical Services.

Providers must maintain CARF accreditation to receive MaineCare reimbursement. CARF accreditation is for a specified period of time and requires periodic review and approval. To maintain accreditation beyond the expiration date, a provider must be resurveyed by CARF, by the expiration date or be in the process of a resurvey by the expiration date. Evidence that the resurvey visit has been scheduled can indicate that the resurvey process is underway, as long as the visit was scheduled prior to the expiration date. MaineCare reimbursement will be subject to recoupment, back to the day on which accreditation expired, if CARF accreditation is denied. The facility must provide to the office listed below written evidence of the scheduled CARF survey visit. Evidence of current CARF accreditation, upon receipt, must also be submitted to this office:

Provider File Unit
Bureau of Medical Services
11 State House Station
Augusta, ME 04333-0011

Each provider must have a written agreement for services with, or shall employ, a physician, a neuropsychologist, and other professional personnel to assure appropriate supervision, medical review and approval of services provided.

102.08 **POLICIES AND PROCEDURES** (Cont)

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The director must have responsibility for the overall management of the service and have two years experience in the rehabilitation of individuals with brain injury, as well as have management and specific training which will enable the director to understand and respond to the unique needs of individuals with brain injuries. The director must be actively involved in the service and provide oversight for day-to-day operations.

If a CARF accredited service plans to add a new BI service component that will require CARF accreditation (CARF requires new services to be delivered for at least 6 months prior to a survey visit), the provider may receive MaineCare reimbursement for these new services while working toward CARF survey and certification, so long as the Department is notified in writing at least 2 months in advance of the intent to seek CARF certification and the date services will start. Additionally, the CARF survey visit must be scheduled prior to the end of the 6-month period, i.e. a survey visit must be scheduled, not necessarily completed, and the Department notified in writing of the CARF survey appointment date. Reimbursement for the new service component will be subject to recoupment, back to start date of the new services, if CARF accreditation is denied.

102.08-2 Setting

These services are intended to be provided on an outpatient basis. However, services may, in some instances, be provided in other settings if the treatment plan addresses the medical necessity for the member to receive services outside of the outpatient setting. All facilities providing rehabilitative services must be accessible to people with disabilities, in accordance with Section 504 of the Rehabilitation Act of 1973, as amended (29 USC, Section 794), and the Americans with Disabilities Act of 1990, (42 USC, 1281 et seq.).

102.08-3 Start of Care

A. The provider must notify the Department of a member's start of care (SOC) date, which is the first billable day of service. The SOC form must be submitted to the Department within 14 days of admission. The form must indicate the member's assigned level of care. The Department must classify each member as eligible for Level I, II or III, before reimbursement begins.

   The Department, at its discretion, may require providers to submit some or all of the following documents to the Department or its Authorized Agent:

   1. Start of Care form (within 14 days of admission);

   2. A completed Brain Injury Assessment Tool (within 14 days of admission);

102.08 **POLICIES AND PROCEDURES** (Cont)

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3. A copy of the completed clinical evaluation (within 30 days of admission); and

4. A copy of the treatment plan.

B. If a member receives a clinical evaluation, and the provider determines that the member does not have a qualifying brain injury diagnosis, or otherwise does not qualify for services under this Section, then the member will only be covered for the clinical evaluation service.

102.08-4 Utilization Review

A. The member's ongoing need for services is subject to utilization review according to the schedule in Section 102.08-4(B) below. Utilization review must:

1. Be based upon the member's clinical evaluation, treatment plan and progress notes (described in Section 102.08-7), the completed Brain Injury Assessment Tool and other relevant documents as may be requested by the Department. Copies of these documents must be submitted to the Department or its Authorized Agent, upon request;

2. At the discretion of the Department, include a face-to-face assessment of the member by the Department or its Authorized Agent;

3. Assess the member's progress toward goals in the treatment plan;

4. Determine the member's rehabilitation potential (defined in Section 102.02-8);

5. Determine the member's continued eligibility and appropriate level of care for classification, according to Section 102.03;

6. Determine and/or authorize the appropriate amount, duration and frequency of specific services to be delivered. UR may result in changes to the member's treatment plan, including reductions in or termination of services (see Section 102.08-4(C) below);

7. Review all other relevant services (regardless of payer) the member is receiving and coordinate rehabilitative services with other services to avoid any duplication;

102.08 **POLICIES AND PROCEDURES** (Cont.)

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8. Approve the member's next classification period start and end dates, as appropriate, and notify the Department;

9. Document UR findings in a format approved by the Department.

B. Utilization review is required for each member according to the following schedule:

1. For Level I services: every 2 months.

2. For Level II services: every 3 months.

3 . For Level III services: every 6 months.

C. If UR findings show the member no longer needs services, or needs fewer services, the member must be given 10 calendar days advance written notification (except in certain circumstances as set forth in Chapter I, member appeals) of the effective termination or reduction in services. A member has the right to appeal a decision to reduce or terminate services, unless it is the result of the application of service caps outlined in the MaineCare Benefits Manual. For detailed requirements regarding advance notifications and member appeal rights, refer to the Member Appeals section of Chapter I, MaineCare Benefits Manual.

D. The Department, the Department's Authorized Agent, or the provider agency will conduct utilization review activities, at the discretion of the Department. Providers will be responsible for performing utilization review activities until such time as the Department provides advance written notice regarding the appointment of an Authorized Agent responsible for all or some utilization review activities.

E The Department must authorize rehabilitative services for a specified classification period in order for services to be covered. In order for reimbursement to continue uninterrupted from one classification period to the next, it is the responsibility of the provider to submit a request for UR five calendar days prior to: 1) the end date of the member's current classification period; and/or 2) the member's scheduled UR, as required by the Department. If the provider does not submit a timely request for UR, and continuing services are delivered without an authorized classification period, the services will be not reimbursable. The provider must not bill the member for any unauthorized services that are delivered. (Refer to Chapter I, Section 1.06-4 for details regarding the billing of members for non-covered services.) Timely performance of UR is the responsibility of the Authorized Agent when the Authorized Agent is performing this function. If the provider is performing UR it must be done according to the timeframes described in this Section.

102.08 **POLICIES AND PROCEDURES** (Cont.)

Effective 11-1-04 102.08-5 Professional and Other Qualified Staff

All professional staff must be conditionally, temporarily, or fully licensed as documented by written evidence from the appropriate governing body for the State or province in which services are provided. All professional staff must provide services only to the extent permitted by licensure. The following staff may provide services:

A. Physician

B. Neuropsychologist

In addition to licensure as a psychologist, a neuropsychologist must meet either criterion 1, 2, or 3 below:

1. Be board certified by The American Board of Professional Psychology-American Board of Clinical Neuropsychology (ABPP-ABCN);

2. Be board eligible: meets training and experience requirements, for The American Board of Clinical Neuropsychology (ABCN) as documented by their letter to that effect, but has not taken the examinations; or

3 Be a Ph.D. in neuropsychology, or Ph.D. in clinical psychology, and have knowledge of neuroanatomy, neuropathology and neuropsychology, as demonstrated by formal course work (documented on transcripts) and/or American Psychological Association (APA)-approved workshops (one hundred clock hours); and must have three years full-time equivalent experience in neuropsychology in a clinical setting, one year of which must have been supervised. The supervised year must be made up of at least fifteen hundred clock hours, accumulated over no more than three calendar years.

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Effective 11-1-04 C. Registered Nurse

D. Certified Therapeutic Recreation Specialist

A certified recreational therapist must have completed a four-year program in therapeutic recreation from an accredited college or university, and be certified as a therapeutic recreation specialist under the National Council for Therapeutic Recreation Certification.

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102.08 **POLICIES AND PROCEDURES** (Cont.)

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F. Certified Occupational Therapy Assistant, Licensed (COTA, L)

An occupational therapy assistant must work only under the supervision of an occupational therapist.

G. Physical Therapist

H. Licensed Physical Therapist Assistant

A physical therapist assistant must work only under the supervision of a physical therapist.

I. Speech Language Pathologist

J. Speech-Language Pathology Assistant

A speech-language pathology assistant must be registered under the license of a speech-language pathologist in the state or province in which services are provided; and work only under the supervision of that speech-language pathologist.

K. Social Worker

L. Licensed Professional Counselor

M. Licensed Clinical Professional Counselor

N. Other Qualified Staff

Other qualified staff are staff members, other than professional staff defined above, who have appropriate education, training, and experience in treatment of individuals with brain injury as approved by CARF, have a satisfactory criminal background check annually, and work under documented supervision, conducted at least monthly, by the professionals defined above.

102.08-6 Interdisciplinary Team

Assessment, coordinated service planning, and direct services on a regular and continuing basis must be provided by a coordinated, interdisciplinary team. This team must:

102.08 **POLICIES AND PROCEDURES** (Cont.)

- be the major decision-making body in determining the goals, process, and time frames for accomplishment of the goals and expected benefits of the admission;
- be composed of the treating member of each discipline essential to the individual's accomplishment of the goals and expected benefits of the admission; and
- meet on a formalized basis at a frequency necessary to carry out their decision-making responsibilities. A team conference should occur for each member served at least monthly.

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This team, comprised of the member, family, legal guardian, professional and other qualified staff, must be specifically designated to serve members requiring rehabilitative services and must include a physician and a neuropsychologist. In addition, the interdisciplinary team must include the disciplines in Section 102.08-5 as required on an individual basis in order to receive reimbursement for covered services.

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102.08-7 Clinical Records

A. Diagnosis and Treatment Plan

1. Clinical Evaluation

A clinical evaluation, which must confirm a tentative diagnosis of brain injury, must be done under the direct supervision of a licensed physician who is Board certified, or otherwise Board eligible, in either physical medicine and rehabilitation or neurology, or a neuropsychologist meeting the requirements of Section 102.08-5(B) and by an interdisciplinary team that meets the requirements of Section 102.08-6, and be included in the member's clinical record. The evaluation must include the member's medical and social history, an assessment of the scope and success of acute care provided as a result of the brain injury, and the member's diagnosis. The evaluation must also identify and list all other relevant services the member is currently receiving, regardless of payer, so that services can be coordinated and any duplication of services avoided.

2. Individual Treatment Plan

Based on the clinical assessment of the member, an individual treatment plan must be developed. This plan must be in writing and identify all specific services to be provided (including those services not MaineCare reimbursable), the frequency and duration of each service, who will provide the service and the goals of each service.

102.08 **POLICIES AND PROCEDURES** (Cont.)

The member shall be informed about the treatment options available to meet his or her needs and the member's preferences shall be taken into consideration in the development of the treatment plan. The plan must be specific to meeting the member's identified needs. Rehabilitative services must be coordinated with all other services the member is receiving as well as avoid any duplication of services. The plan must be approved, signed, and dated by a physician or neuropsychologist within thirty days of the date the member began treatment and must specify the clinical services to be provided, the frequency and duration of each phase of service, the expected duration of treatment, and the expected rehabilitative goals or outcomes of services.

The treatment plan must be reviewed by a professional staff member and reauthorized, signed and dated by a physician or neuropsychologist at least every thirty days.

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3. Treatment Documentation

Written treatment or progress notes must be maintained in accordance with the treatment plan and be made at least every two weeks. All entries must identify who provided the service, date of each service, its duration and progress the member is making toward attaining the goals stated in the treatment plan. The individual performing the services must sign all entries. The interdisciplinary team must review the treatment plan on a monthly basis, and maintain written notes of all meetings.

For each service covered under this Section that is delivered in the member's home or residence (including PNMIs), the provider must maintain records that show the arrival and departure times of each care provider, for type of provider (e.g. RN, OT, PT, therapeutic recreation specialist, other qualified staff, etc.), for each visit, and the total time spent in the home/residence for each provider, excluding travel time. This information must be documented in a clear and concise format and available to the Department, upon request.

The clinical record must also include written reports on all medication reviews, consultations, testing, evaluations, and collateral contacts made on behalf of the member.

B. Referral, Discharge, and Follow-up

A discharge summary must be signed and dated and included in the clinical record. The summary must include:

102.08 **POLICIES AND PROCEDURES** (Cont.)

1. Indicators used to determine the success of all goals and objectives identified in the plan(s) of service; and

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2. A written plan of follow-up care. The rehabilitative provider must provide for its own follow-up care when this is appropriate for those people who remain in its service area. Arrangements to facilitate follow-up care must be made for those who will leave the geographic service area. The follow-up plan must provide for:

   a. referral and forwarding of clinical information to a designated physician and/or service program;

   b. provisions for re-evaluation of status as appropriate and feasible;

   c. specific recommendations for medical, neurological, physical, cognitive, behavioral, psychological, and family management; and

   d. designation of an individual responsible for case management after discharge to assure continuity and coordination of post discharge services.

102.08-8 Surveillance and Utilization Review

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All providers are subject to the Department's Surveillance and Utilization Review activities. Refer to Chapter I, General Administrative Policies and Procedures for rules governing these functions.

102.09 **REIMBURSEMENT**

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The amount of payment for services will be the lowest of the following:

A. the appropriate amount listed in the Chapter III, Section 102, "Allowances for Rehabilitative Services;"

B. the amount allowed by the Medicare carrier; or

C. the usual and customary charge.

102-10 **BILLING INSTRUCTIONS**

Providers must bill on the HCFA 1500 using the procedure codes in Chapter III and in accordance with the Department's billing instructions for Rehabilitative Services.

Appendix I

PROVISIONAL ACCREDITATION PROCESS

Effective 11-1-04 The purpose of this Appendix is to describe the initial eighteen-month approval process for providers who are not ready to undergo the Rehabilitation Accreditation Commission (CARF) survey and certification and are requesting MaineCare reimbursement under this Section. The initial approval process is intended to assure the Maine Department of Health and Human Services that the applicant agency has a thorough understanding of the requirements of this Section, has sufficient clinical and administrative capability to carry out the intent of this Section, and has taken steps to assure the safety, quality, and accessibility of the service.

Effective 11-1-04 The Department will administer the initial approval process.

Step #1 - Identification of Provider and Verification of the Provider's Intent to Undergo the Provisional Accreditation Process

Effective 11-1-04 A. The director or administrator of the applicant agency must contact the Department to request the initiation of the process. The applicant agency's request must be accompanied by the following information:

1. Name of the agency (and the legal entity sponsoring the facility if different);
2. Address of the agency;
3. Name of agency contact person;
4. Telephone number of agency contact person; and
5. Estimated number of individuals to be served (service capacity).

Effective 11-1-04 B. The Department will start the review process. A representative of the Department will contact the agency within ten (10) working days of receipt of the identification information in order to:

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1. Identify the Department’s representative assigned to carry out the review process;
2. Provide clarification regarding the process; and
3. Request written information to use in the document review phase of the process.

Step #2 - Document Review

Effective 11-1-04 This part of the process must be initiated at least 30 days prior to the date when the agency proposes to provide services for MaineCare reimbursement under this Section. If the agency satisfies the requirements of this review, the Department will provisionally certify the agency for ninety (90) days from the first date of service for which MaineCare reimbursement is requested. In order to continue

certification beyond this period, the agency must (during the 90-day period) have undergone the on-site survey described in Step #3 of this Appendix and been granted continued approved status as a result of that review.

Effective 11-1-04 The following requirements must be satisfied to gain 90-day provisional certification. Additionally, the provider must show it will be in compliance with the MaineCare Benefits Manual requirements.

A. Compliance with applicable legal requirements and regulations of all governmental and legally authorized agencies under whose authority the agency operates. These include, but are not limited to, those regulations regarding equal employment opportunity, state and federal wage hour regulations, health and safety codes, and affirmative action. The applicant must submit documents demonstrating compliance with such regulations.

Effective 11-1-04 B. Provision of documents providing the legal basis for the organization and identifying the members of the governing body or, in the case of a proprietary organization, the designated authority. The documents must identify the chief executive of the organization.

C. Provision of by-laws, or other applicable documentation, describing and governing the purpose, scope and activities of the organization.

D. A narrative history of the organization, which provides a brief history of the agency's activities.

E. A description of the agency's services, with particular attention to those governed by Section 102 of the MBM. Service descriptions must include the purpose of each service and be written so as to govern the direction and character of each service.

Effective 11-1-04 F. The agency's criteria for admission/entrance to the service being reviewed.

G. Policies and procedures that address activities associated with member intake, assessment, individual planning, case coordination, and record keeping.

H. The agency's actual or projected staffing plan. This plan must identify staff providing covered services. There must be clear indication of which staff are actually employed by the agency at the time of Document Review.

I. Qualifications of all staff, consultants, independent contractors, trainees/interns, and volunteers.

J. Policies that address member rights and preserve confidentiality. These policies must meet the requirements of Chapter I of the MaineCare Benefits Manual.

K. Policies and procedures regarding quality assurance.

L. Proof of liability insurance covering the services reimbursed under this Section.

Effective 11-1-04 Within thirty (30) days of receipt of all information required by Step #2, the Department will issue a decision regarding the findings of the Document Review to the agency and to the Bureau of Medical Services. The finding will document all areas found to be non-compliant with the requirements of Step #2 and will stipulate corrective action which must be accomplished to obtain 90-day provisional certification.

Effective 11-1-04 The agency must request an application for MaineCare enrollment from Provider File at the Bureau of Medical Services. Provider File will then process the agency application in order to begin MaineCare reimbursement after receiving the 90-day provisional certification.

Step #3 - On-Site Review

Effective 11-1-04 Within ninety (90) days of the first date of service provided under this Section, the agency must have undergone an On-Site Review.

It will be the responsibility of the applicant agency to contact the Department's representative who conducted the Document Review to arrange for the On-Site Review. The agency must request the On-Site Review at least thirty (30) days prior to the requested date of the Review.

Effective 11-1-04 The On-Site Review Team will consist of at least two representatives of the Department of Health and Human Services. The team may also include a licensed practitioner of the medical profession with expertise in the area of brain injury rehabilitation. In the event the Department requires such a clinician as a member of the review team the costs of the clinician's services must be reimbursed by the agency being reviewed.

Effective 11-1-04 The On-Site Review will be scheduled for up to four days. The reviewers will, through the inspection of the agency documents, interviews and observation, determine the extent to which the agency is in compliance with the policies and procedures previously submitted by the agency as well as the agency's compliance with all requirements of this Section of the MaineCare Benefits Manual. Particular attention will be given to items identified as requiring correction in the Document Review report.

The following represents the On-Site Review Team activities:

1. Orientation Session. The On-Site Review Team meets with agency staff and representatives of the governing body to clarify the purpose of the survey and explain each team member's role in the review. This is an opportunity for agency staff and representatives to ask questions about the process and provide files and records necessary to carry out the review. At this time the review team must be assigned a secure work space (where confidential material can be safely stored) and a separate area where interviews can be held. Staff interviews shall be arranged at this time.

2. A tour of the physical plant.

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3. Record reviews, interviews with staff, board members, members, family members, representatives, or others, and program observation. The agency must post signs on a readily viewed area that the review is being performed and reviewers are available to meet with members in private if requested.

4. On-Site Review Team meeting to coordinate findings and clarify questions requiring more attention.

5. Information gathering.

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6. Exit interview with representatives of administration, the governing body, and staff. This is the agency's opportunity to question interpretations or findings of the Review Team. Any member or legal guardian who requests to attend the exit interview shall be allowed to do so.

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The On-Site Review Team will write a report of its findings, including strengths and areas requiring improvement. The report will make recommendations regarding the continuation of provisional certification as well as listing corrective action the Team deems necessary. The report will be submitted

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to the Director of the Bureau of Medical Services and to Provider File at the Bureau of Medical Services within twenty (20) days of the completion of the On-Site Review. A copy of the report will be sent to the contact person at the applicant agency.

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The Department will notify the agency of the decision regarding continuation or revocation of the agency's provisional certification status within ten (10) days of the receipt of the On-Site Review Team report. Agencies that fail to substantially meet the requirements outlined in Step #3 will have their provisional certification revoked. In the event of revocation, the Bureau of Medical Services will stop MaineCare reimbursement as of the date of revocation. Any agency that is denied the continuation of

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provisional certification may appeal this decision. The appeal process is defined in Chapter I of the MaineCare Benefits Manual.

All three steps defined in this Appendix must be completed in order for the agency to receive the eighteen-month provisional certification.

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The provisional certification will be awarded one time only, for a total of eighteen (18) months from the first date of service, including the 90-day certification defined in Step #2 of this Appendix.

Complaints made to the Department regarding an agency that has a provisional certification or is in the process of receiving a provisional certification will be investigated. The Department must determine the validity of the complaint and must withdraw the provisional certification or discontinue the process of reviewing the agency for provisional certification, whichever is appropriate, if the Department determines that the health or safety of a member receiving services is in jeopardy.

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In the event that the Department determines the applicant is out of compliance with the requirements of any applicable policy, or when non-compliant items represent a threat to the health, safety, or rights of members to be served under this policy, the Department must refuse or withdraw provisional certification to the applicant. In the event the provisional certification is refused or withdrawn, the Department's

decision may be appealed. Requests for hearings must be made, in writing, within ten days of agency notification of an adverse decision. The appeal process is defined in Chapter I of the MaineCare Benefits Manual.

Effective 11-1-04 Each eligible program is allowed one eighteen-month provisional certification only. CARF accreditation must be obtained by the end of the eighteen-month provisional certification, or MaineCare will stop reimbursement until CARF accreditation is obtained.

Effective 11-1-04 If the application for CARF accreditation has been submitted and a review is scheduled, one three-month extension of the provisional certification will be granted by the Department.

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ALLOWED AGE	PROC CODE	DESCRIPTION	MAXIMUM ALLOWANCE
ALL AGES	Z9516	CLINICAL EVALUATION	$20.00/ 15 MINUTES
ALL AGES	Z9517	LEVEL I INTENSIVE REHABILITATIVE SERVICES	$20.00/ 15 MINUTES
ALL AGES	Z9517-HQ	LEVEL I INTENSIVE REHABILITATIVE SERVICES-- GROUP	$20.00/ 15 MINUTES
ALL AGES	Z9518	LEVEL II POST ACUTE REHABILITATIVE SERVICES	$16.25/ 15 MINUTES
ALL AGES	Z9518-HQ	LEVEL II POST ACUTE REHABILITATIVE SERVICES-- GROUP	$16.25/ 15 MINUTES
ALL AGES	Z9519	LEVEL III DAY HEALTH REHABILITATIVE SERVICES	$11.25/ 15 MINUTES
ALL AGES	Z9519-HQ	LEVEL III DAY HEALTH REHABILITATIVE SERVICES-- GROUP	$11.25/ 15 MINUTES